VERMONT

Office of Vermont Health Access *Agency of Human Services*
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

~VIVITROL~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of Vivitrol (naltrexone for IM extended release suspension). These criteria are based on concerns about safety. In order for beneficiaries to receive coverage for Vivitrol, it will be necessary for the prescriber to complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via Fax: 1-866-767-2649

Prescribing physician:

Name:_____

Phone #:_____

Fax #:_____

Address:_____

Beneficiary:

Name:_____

Medicaid ID #:_____

Date of Birth:_____Sex:_____

Diagnosis:_____

Contact Person at Office: _____

Administering physician:

Name: _____ Address: _____

Pharmacy (required)**:**_____ Phone:_____ &/or FAX:_____

QUALIFICATIONS

MDs	Prescribers must secure direct delivery of Vivitrol from the pharmacy to the physician's office. Pharmacies may not dispense Vivitrol directly to the patient. Vivitrol **<u>may not</u>** be billed through the Medical Benefit as a J-Code J2315.
Patients	Patients must have a diagnosis of alcohol dependency. Patients must also have had an inadequate response, adverse reaction, or contraindication to 2 out of 3 oral formulations including: oral naltrexone, acamprosate, and disulfiram OR a compelling clinical reason for Vivitrol use. Patients should be opiate free for > 7 -10 days prior to initiation of Vivitrol.

PROCESS

► Please answer the following questions:

Does the patient have a diagnosis of alcohol dependency?	□ Yes □ No
Has the patient tried any of the following? Please document below. oral naltrexone: □ side-effect □ non-response □ allergy acamprosate: □ side-effect □ non-response □ allergy disulfiram: □ side-effect □ non-response □ allergy	□ Yes □ No
Has patient had a recent hospital admission for alcohol detoxification?	□ Yes □ No If yes, date: ____/_____/____
Has the patient been opiate free for > 7 – 10 days	□ Yes □ No
Comments and additional patient history:	

Prescriber Signature: _____ Date of request: _____

Last Updated 12/07